Authorization to Release Laboratory Results to Patient or Patient's Legally Authorized Representative (Authorization to Disclose Protected Health Information)

This authorization complies with the requirements of §164.508 of the HIPAA Privacy Standards (45 CFR, Parts 160 and 164). ***Requester must present current valid government-issued photo identification and other required documentation confirming legally authorized representative status at the time of request.*** *If all fields are not complete, results may not be provided.*

Patient Information:

Name: _____ _____ _____
Last Name First Name Middle Initial

Address: _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Phone number: (____) ____-____

Date of Birth: _____ **Social Security Number*:** _____

***If requesting Newborn Screening laboratory results, use mother's Social Security Number.

Requestor Information:

If the Individual whose laboratory results are requested is under the age of 18 or has a legally authorized representative (LAR) as defined below, the Individual's parent or LAR must complete the following and submit a copy of the documentation establishing the LAR's relationship to the Individual:

_____
(Name of Person / Entity authorized to receive Individual's information)

_____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Phone number: (____) ____-____

"<u>Legally Authorized Representative</u> (LAR)" (check the applicable relationship):

____A parent or legal guardian if the Individual is a minor;

____A legal guardian if the Individual has been adjudicated incompetent to manage the Individual's personal affairs;

____An agent of the Individual authorized under a Medical Power of Attorney;

____An agent of the Individual authorized under a Durable, Statutory or non-medical Power of Attorney, limited to certain powers over benefits from certain governmental programs, including without limitation Medicaid, as defined by Texas Estates Code §752.112, effective Jan. 1, 2014.

____An attorney ad litem appointed for the Individual;

____A guardian ad litem appointed for the Individual;

____A personal representative or statutory beneficiary if the Individual is deceased (If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate);

____An attorney retained by the Individual or by another person listed herein; or

____To a state-designated protection and advocacy system (such as the Department of Family and Protective Services) to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law.

Patient Name: _____ **Requestor's Phone Number: (____) ____-_____**

Lab Result Information:

Facility/Provider Collecting Specimen: _____
(Specify the Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, Governmental entity, etc.)

Address of Facility/Provider: _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Specific Month/Year of Test: _____

I authorize the Department of State Health Services to disclose the following specific laboratory results to the Individual or LAR.

Yes ( ) No ( ) Laboratory results. Indicate **specific** tests:

_____

If requesting HIV test results, indicate CDC Number **and** alias provided (if applicable):

_____

I understand that: 1) I may revoke this authorization in writing by contacting the DSHS office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on the date that DSHS either discloses the requested laboratory results to Individual or LAR or determines that it is unable to fulfill the request.

This form (___) was read by me (___) was read to me and I understand its purpose and content. All blanks were completed or struck through before I signed the form. I hereby certify that all information provided on this form is true and correct. I understand that submitting false information on a government form in Texas is a criminal offense under Texas Penal Code Sec. 37.10.

_____ _____
Signature of Individual, Parent of Individual, **if minor, or LAR of Individual** Date signed

_____
Print/Type Name of Individual, Parent, or LAR. State authority to act on behalf of the individual. Attach photo identification and documents to support authority (e.g., birth certificate, guardianship order, medical power of attorney).

If the Individual or LAR is physically unable to sign and gives verbal authorization, the undersigned two witnesses attest that they witnessed such verbal consent:

_____
Print/Type Name of Witness

_____ _____
Signature of Witness Date signed

Patient Name: _____ **Requestor's Phone Number:** **( ) -**

If the Individual, Parent or LAR is not present or is physically unable to sign, the undersigned additional witness attests that the Individual, Parent or LAR verbally gave Authorization to Release Laboratory Results.

_____
Print/Type Name of Witness

_____ _____
Signature of Witness Date signed

Please check the format you prefer: ☐ **facsimile - include fax number:** **( ) -**
☐ **mail to above address**

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us/ for more information.

Instructions for Obtaining Authorization to Release Medical Information

Information contained in client records is confidential. With certain exceptions, the release of medical records is prohibited by the provisions of the Medical Practice Act (Article 4495b, V.T.C.S.). In addition, social, financial, educational and other types of information in client files may be protected by a constitutional or common law right to privacy. There are civil and criminal penalties for the unauthorized release of such information.

The Medical Practice Act, the common law and the Constitution permit a health care provider to release these types of information from an individual's record with the consent of the individual or a person authorized to consent for the individual. For example, the Medical Practice Act states:

> Occupations Code Sec. 159.005(a)(1-5) and (b). Consent for the release of confidential information must be in writing and signed by the patient, or a parent or legal guardian if the patient is a minor, or a legal guardian if the patient has been adjudicated incompetent to manage his personal affairs or an attorney ad litem appointed for the patient, as authorized by the Texas Mental Health Code; the Persons With Mental Retardation Act; Chapter XIII, Texas Probate Code, and Subtitle B Title 5, Family Code; or a personal representative if the patient is deceased, provided that the written consent specifies the following:
>
> (A) the information or medical records to be covered by the release;
> (B) the reasons or purposes for the release; and
> (C) the person to whom the information is to be released.

Further, the Communicable Disease Prevention and Control Act (Chapter 81, Health and Safety Code) contains the following specific requirements for the release of information relating to tests for AIDS, the human immunodeficiency virus (HIV), and antibodies to HIV:

> Sec. 81.103(d). An Authorization under this subsection must be in writing and signed by the person tested or the person legally authorized to consent to the test on the person's behalf. The authorization must state the person or class of persons to whom the test results may be released or disclosed.

The "Authorization to Release Laboratory Results" form was developed to conform to these statutory requirements. For this reason, when you are requested to release information from records under your control, the form must be carefully completed to provide the information required by statute. If you are requested to provide information from a client record to an institution (e.g., a hospital) rather than an individual, and you do not know the name of the individual within the institution to whom the information is to be sent, insert the title of the responsible person (e.g., the administrator, medical records librarian, etc.). Do not simply insert the name of the hospital.

The "Authorization to Release Laboratory Results" form must be completed and signed by individual clients when they request their personal health records be released.

The form may be used to obtain information from other providers and when used for that purpose, it should be completed with the same concern for the statutory, common law and constitutional requirements. Such attention to detail may ultimately save both time and effort.

The Medical Practices Act, the Communicable Disease Prevention and Control Act and certain other statutes, for instance, those relating for mental health and mental retardation information, provide several other exceptions to the rule of confidentiality relating to medical records.

ANY REQUEST FOR INFORMATION WHICH CANNOT BE ADDRESSED BY THE USE OF THIS AUTHORIZATION TO RELEASE LABORATORY RESULTS FORM MUST BE REFERRED IMMEDIATELY TO THE OFFICE OF GENERAL COUNSEL FOR NECESSARY ACTION. Because the Public Information Act and other statutes give a very limited time period during which the agency must respond to requests for information, any delay in making these referrals may lead to results which are adverse to the agency.

Please review the release form before releasing information. All blanks on the form must be filled in, the form must be read by the client, and the form must be appropriately signed before the information is released. The client must receive a signed copy of the authorization.